

## OFFICE OF THE PATIENT ADVOCATE (OPA)

**Mission:** *To inform and educate consumers about their rights and responsibilities as HMO enrollees in order to ensure that they are able to make the best use of their HMOs.*

**Program Name:** *HMO Report Card*

**Functions:**

1. Produce a website that provides comparative quality ratings for the State's largest HMOs and medical groups.
2. Produce and distribute a printed summary of the HMO report card site.
3. Conduct a media campaign to launch/publicize the report card.

**Goals/Outcomes:**

1. Comprehensive, comparative, and user-friendly quality information that consumers can use to choose among HMOs and medical groups.
2. Access to HMO report card information for consumers who do have internet capability.
3. Public accountability and market pressure for improvement in quality of care.
4. Improvement in the quality of care provided by California HMOs and medical groups.

**Budget:** \$1.25 Million, 2.5 Personnel Years

Note: Of the other states considered for comparison (Arizona, Florida, New Mexico, Oregon, Texas, and Washington), only New Mexico and Washington produce anything similar (but not the same) as California. Data on fiscal resources specifically allocated to these activities in New Mexico and Washington were not available.

**Customers:** Primary: HMO Enrollees – Satisfaction measured by number of website and print card users for web, responses to user survey, and responses to focus group testing.

Secondary: HMOs and Medical Groups – Satisfaction measured by feedback from the California Cooperative Healthcare Reporting Initiative (an industry collaborative) and initiation of quality improvement efforts by HMOs and medical groups.

**Obstacles:**

1. Limited data availability.
2. Lack of consensus on scoring methodologies.
3. Limited consumer knowledge and interest in health care quality.
4. Industry resistance to publishing negative quality scores.

**Relationship to OPA Mission:** This activity is both consistent and an integral part of informing consumers about how to make the best use of their HMOs and medical groups. It is specifically required by state statute.

**METRIC 1:** *Number of users (as measured by the number of visits and visitors to the report card website; the number of local outlets participating in hard copy distribution; number of hard copies distributed).*

- 1) This metric measures the “reach” of the report card, i.e., how many consumers have been informed and educated, and is a necessary first step to evaluating the impact of this education strategy.
- 2) The intent is to maximize the number of consumers who use the report card to make informed choices among HMOs and medical groups; therefore, the more users who view the website or receive a hard copy, the more effective this strategy can be.
- 3) The better the content, user-friendliness, and distribution of the report card, the more consumers will be able to use it effectively. Annual evaluation of the report card (through focus groups, user surveys, and outside evaluators) guides improvement strategies targeted at maximizing these enabling factors. Detailed analysis of the website activity (which pages are visited and how often) identifies which information is most important and useful to consumers. These data indicate where the emphasis should be in changing and improving the report card from year to year.
- 4) The target for the metric is OPA staff, the HMO industry, the public policy arena, and others who are concerned with improving consumer choice and health care quality.

These targets represent the “interested party” community who are most likely to use the data to assist in meeting the OPA mission and the objectives of the report card program.

- 5) Since OPA is a relatively new agency (in operation since July 2000), the annual HMO report card is also relatively new. Annual increases in report card users is natural and to be expected as more consumers become aware of the existence of OPA and its programs.

**METRIC 2:** *Annual percentage improvement in quality and patient satisfaction scores (as measured by HEDIS clinical performance data for HMOs, CAHPS patient satisfaction data for HMOs, and CAS patient satisfaction data for medical groups).*

- 1) This metric measures the ultimate impact of public accountability and market pressure created by the report card on the HMO industry (including medical groups). By making relative HMO and medical group performance a matter of public record, the report card encourages HMOs to strive to do better to maximize their competitive position in the marketplace, and it contributes to (1) increasing access for consumers, (2) improving the services they receive from their HMOs, and (3) creating better choices in the type and quality of care they can expect to receive.
- 2) The metric is used by HMOs and medical groups to assess the quality of their services and target efforts for quality improvement. In addition, it is used by consumer and health care quality advocates to influence HMOs, regulators, and public policy decision-makers in order to effect positive changes in the HMO industry. Finally, it is used by OPA to educate consumers about the differences in quality among HMOs and to assist them in making the best choice of health plan for themselves and their families.
- 3) The quality data in the HMO report card have demonstrated over time an overall (although not universal) improvement in those performance indicators that are reported. HMO comparisons helps identify areas in which an individual plan may be deficient and where that plan stands in relationship to its colleagues in the industry. This gives the HMO information necessary to target resources to areas that need improvement.
- 4) This metric is targeted to consumers, HMOs, consumer advocates, HMO regulators, and public policy makers all of whom play a role in improving the access to and quality of services available to consumers. This is consistent with the state law that established OPA.

- 5) Fluctuations in this metric can be caused by (1) actual changes in HMO/medical group performance; (2) changes in the way the metric is derived; (3) changes in medical standards and practices; and (4) changes in consumer expectations. While the data reporting and collection is standardized by the National Committee for Quality Assurance and the California Cooperative Healthcare Reporting Initiative, OPA analyzes and presents “grades” that take into account overall industry trends and ease of consumer use and interpretation. This may vary from year-to-year.

## **OFFICE OF THE PATIENT ADVOCATE (OPA)**

**Mission:** *To inform and educate consumers about their rights and responsibilities as HMO enrollees in order to ensure that they are able to make the best use of their HMOs.*

**Program Name:** *Consumer Education*

**Functions:**

1. Conduct Mobile Information Centers (MICs) in communities throughout the State.
2. Produce and disseminate California's HMO Guide (Guide).

**Goals/Outcomes:** Consumers that are informed about how to make best use of their HMOs.

**Budget:** \$2.5 Million, 5.0 Personnel Years

Note: OPA is the only state office in the country dedicated to educating HMO consumers so there are no data from other states (Arizona, Florida, New Mexico, Oregon, Texas, and Washington) to compare with regard to cost and staffing.

**Customers:**

Primary: HMO Enrollees – Satisfaction measured by number of consumers contacted, direct feedback from face-to-face encounters, feedback on website customer survey, focus group testing results for printed materials, independent evaluations.

Secondary: HMO Industry, Consumer Advocate/Assistance Organizations, Other Governmental Agencies – Satisfaction measured by willingness to assist and collaborate with OPA's programs.

- Obstacles:**
1. Size/diversity of the target population (17.5 million enrollees)
  2. Complexity of the HMO industry.
  3. Limited consumer knowledge and interest about HMOs.
  4. Few existing models to work from.
  5. Generally poor quality of existing educational materials.

**Relationship to OPA Mission:** This activity is both consistent and an integral part of informing consumers about how to make the best use of their HMOs. It is specifically required in state statute.

**METRIC 1:** *Number of Mobile Information Center (MIC) events and face-to-face consumer contacts made at MIC events.*

- 1) This metric measures the “reach” of the MIC program, i.e., how many consumers have been informed and educated (OPA's primary mission) through a face-to-face contact. Since the MIC is also one of the primary ways of distributing OPA printed materials (Guide, HMO Report Card, etc.), it also contributes significantly to the success of those program components. Consequently, this metric is an important input for those activities as well.
- 2) These data are used to evaluate opportunities to interface and connect with the target population and to prioritize community outreach activities for OPA (and its contractors) by identifying the most cost effective ways to reach the maximum number of consumers.
- 3) The more consumers that come in contact with OPA staff (including contractors) and its educational materials, the greater the opportunity for those consumers to obtain and use information that will assist them in making the best use of their HMO services. This metric is a direct measure of that. The metric is monitored on a monthly basis by OPA staff and used to make short and long term adjustments to outreach and education strategies.
- 4) The target for the metric is OPA staff and its contractors and was developed by OPA as its primary outreach measurement.

- 5) Since OPA is a relatively new agency (in operation since July 2000), annual increases in the number of MICs conducted and face-to-face contacts reported are expected as more consumers become aware of the existence of OPA, as OPA identifies more opportunities for MIC events, and as OPA increases the number of contractors participating in MICs.

**METRIC 2:** *Number of Guides distributed by county and per capita (HMO member).*

- 1) This metric measures the “reach” and penetration of the Guide into its target audience. Evaluation of the Guide has indicated that it is well-received and useful to consumers. The Guide, an important adjunct to the MIC program, provides consumers with information that is more comprehensive than what can be covered in a face-to-face MIC contact. The Guide can also be distributed to consumers in many other venues (outside the MIC) by HMOs, medical groups, consumer advocate organizations, etc.
- 2) The metric is used by OPA and the Center for Community Wellness (the contractor that produced the Guide for OPA) to evaluate the effectiveness of the distribution system and to determine future target areas of the State for focused distribution.
- 3) To date, distribution of the Guide to consumers, has been limited solely by the number of Guides produced. In its first year, 350,000 were produced and all were distributed in a period of six months. It is, therefore, assumed that the more Guides produced, the more will be distributed. Production is limited by the amount of fiscal resources available.
- 4) The metric was developed and is used by OPA to assess the success of the Guide project. It reflects OPA’s goal of reaching as many consumers as possible with the widest geographic distribution that is feasible.
- 5) As noted before, distribution and penetration of the Guide into its target population has to-date been determined by the number of Guides produced. Fluctuations from year-to-year will, therefore, depend on the amount of resources available and dedicated to production. These resources are expected to vary as a result of annual prioritization of OPA’s program activities.

